No. 92-569

In the Supreme Court of the United States

OCTOBER TERM, 1992

NATIONAL KIDNEY PATIENTS ASSOCIATION, ET AL., PETITIONERS

v.

LOUIS W. SULLIVAN, SECRETARY OF HEALTH AND HUMAN SERVICES, ET AL.

ON PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE DISTRICT OF COLUMBIA CIRCUIT

BRIEF FOR THE RESPONDENTS IN OPPOSITION

KENNETH W. STARR
Solicitor General

STUART M. GERSON
Assistant Attorney General

ANTHONY J. STEINMEYER
ROBERT M. LOEB
Attorneys

Department of Justice
Washington, D.C. 20530
(202) 514-2217

QUESTION PRESENTED

Whether a Medicare claimant must present a claim for payment before seeking judicial review of a Medicare policy or regulation governing the method of determining the amount or the allowance of Medicare benefits.

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OPINIONS BELOW

The opinion of the court of appeals (Pet. App. 1a-22a) is reported at 958 F.2d 1127. The opinion of the district court (Pet. App. 23a-35a) is reported at 754 F. Supp. 900.

JURISDICTION

The judgment of the court of appeals was entered on March 13, 1992. A petition for rehearing was denied on June 1, 1992. Pet. App. 59a. On July 29, 1992, the Chief Justice extended the time for filing a petition for a writ of certiorari to and including September 29, 1992. The petition was filed on September 29, 1992. The jurisdic-

tion of this Court is invoked pursuant to 28 U.S.C. 1254(1).

STATEMENT

1. Title XVIII of the Social Security Act, as added by the Health Insurance for the Aged Act, Pub. L. No. 89-97, § 102(a), 79 Stat. 291—popularly known as the Medicare Act—establishes a health insurance program for eligible aged and disabled persons. 42 U.S.C. 1395 *et seq.* The Medicare Program is administered by the Secretary of Health and Human Services (HHS) through the Health Care Financing Administration (HCFA). The Act is divided into two parts. Part A of the Act authorizes payment for hospital and related post-hospital services. 42 U.S.C. 1395c to 1395i-4 (1988 & Supp. II 1990). Part B of the Act authorizes payment for supplementary medical services. 42 U.S.C. 1395j to 1395w-4 (1988 & Supp. II 1990). This case involves reimbursement under Part B for home kidney dialysis equipment and supplies.

There are two methods of obtaining reimbursement under Part B for home dialysis equipment and supplies. Under Method I, certified facilities are reimbursed based on a formula established by the Secretary. 42 U.S.C. 1395rr(b)(1)(A) and (b)(7). Under Method II, entities that are not certified facilities are reimbursed on a "reasonable charge" basis. 42 U.S.C. 1395u(b)(3), 1395rr (b)(1)(B) and (b)(8). See also Pet. App. 2a-3a. The "reasonable charge" generally is the lowest of (1) the supplier's actual charge, (2) its customary charge, or (3) the prevailing charge in the area. 42 U.S.C. 1395u(b)(3). In addition, Congress has directed the Secretary to identify by regulation instances in which the standard criteria would lead to a charge that is "grossly excessive" (or "grossly deficient"), such that the charge is not

"inherently reasonable." 42 U.S.C. 1395u(b)(8)(A). The Secretary has implemented this provision through a regulation that authorizes HCFA or the carrier to determine that a charge is inherently unreasonable and to prescribe a substitute rate. 42 C.F.R. 405.502(g). Method II affords patients who self-dialyze at home the option of contracting directly with a supplier of home dialysis equipment and supplies, instead of receiving home dialysis equipment and supplies from a certified facility.

2. In 1988, petitioner Home Intensive Care, Inc. (HIC), was the largest supplier of home dialysis equipment under Method II in Florida. HIC supplied dialysis equipment and supplies to approximately 1,000 patients at a rate of $3,100 per month. Although Method II payments cover only dialysis equipment and supplies, HIC provided its clients with "free" staff assistants to aid the patients during home hemodialysis sessions. C.A. App. 18, 30-31.

On July 12, 1988, Blue Cross and Blue Shield of Florida (Blue Cross), the local Medicare Part B carrier, issued a notice proposing to reduce the maximum monthly allowance under Method II for home dialysis supplies and equipment from $3,100 to $1,625. Blue Cross solicited comments on the proposed reduction, surveyed dialysis facilities, and requested cost information from dialysis equipment suppliers. Pet. App. 4a; C.A. App. 55-57.

Upon completion of its evaluation of the comments and cost information, Blue Cross determined that the $3,100 charge was unreasonable and that the new monthly payment maximum would become effective on January 1, 1989. C.A. App. 55, 63. In its letter to suppliers, Blue Cross noted that HIC had refused to reveal its acquisition and operating costs. C.A. App. 57. Based on the cost information available from other suppliers,

however, Blue Cross determined that a charge of $3,100 per patient per month was more than three times the suppliers' cost and was "grossly excessive." C.A. App. 56-57. Blue Cross explained that more than 75% of all home dialysis equipment and supplies were provided by Method I providers, and that there was no reason to believe that Method I providers (who charged only $1,625 per month for such services) had lower costs than Method II suppliers. C.A. App. 56-59, 61-62. Blue Cross rejected the argument that the provision of "free" assistants justified the higher Method II rate, explaining that the cost of such assistants is not reimbursable under the Medicare Act. C.A. App. 61.

3. Petitioners—HIC, a renal dialysis patients' group, and ten individual renal dialysis patients who received dialysis equipment from HIC—failed to present a claim for payment under the reduced rate. If petitioners had done so, they could have obtained administrative review of Blue Cross's rate reduction and judicial review of the Secretary's final determination if their claims for increased reimbursement were denied. Instead of presenting a claim, petitioners filed an action directly in the district court seeking to enjoin the rate reduction. Pet. App. 4a. Petitioners' complaint alleged (1) that the general regulation that authorized Blue Cross to find HIC's charge "inherently unreasonable" (42 C.F.R. 405.502(g)) was not properly promulgated; (2) that a transmittal letter issued by the HCFA urging carriers to examine the reasonableness of Part B dialysis equipment rates violated the Medicare Act and was a substantive rule requiring notice-and-comment rulemaking under the Administrative Procedure Act (APA), 5 U.S.C. 553; and (3) that the carrier's decision to reduce the rate was "arbitrary and capricious." Pet. App. 5a.

In December 1988, the district court issued a preliminary injunction, enjoining the Department of Health and Human Services from reducing the rate paid to HIC. Pet. App. 5a.

4. The government appealed the district court's order, arguing, *inter alia*, that the district court lacked jurisdiction because petitioners failed to present a claim for payment covered by the challenged rate reduction and failed to exhaust their administrative remedies. While the case was on appeal, "Congress commanded what the district court had enjoined." Pet. App. 5a. Section 6203(b)(1) of the Omnibus Budget Reconciliation Act of 1989, Pub. L. No. 101-239, 103 Stat. 2235, amended 42 U.S.C. 1395rr(b)(7) to cap Method II home dialysis payments at the Method I level. Pet. App. 5a. As a result of the new legislation, the district court modified its injunction to allow HHS to reduce future payments to HIC. *Ibid.* Thereafter, the court of appeals dismissed the government's appeal from the preliminary injunction as moot, vacated the district court's order, and remanded for consideration of whether the government could recoup overpayments made pursuant to the injunction. Pet. App. 36a-42a.

5. On remand, the district court ruled that HHS could not recover under the injunction bond or recoup any of the payments made pursuant to the injunction. The court concluded that its prior ruling was correct in all respects. The court further held that, even if its prior ruling was in error, it would be inequitable to require HIC to repay any of the money paid to it under the preliminary injunction. Pet. App. 5a-6a, 27a-35a.

6. The court of appeals reversed. Pet. App. 6a-22a. It held that the district court lacked jurisdiction to enter the injunction. In *Heckler* v. *Ringer*, 466 U.S. 602 (1984),

this Court construed the judicial review provisions of the Medicare Act, 42 U.S.C. 1395ff (incorporating 42 U.S.C. 405(g)) and 42 U.S.C. 1395ii (incorporating 42 U.S.C. 405(h)), to require presentment of a claim to the agency ("an absolute prerequisite") and exhaustion of the administrative process ("a prerequisite that may be excused only under rather limited conditions") before a court may assert jurisdiction over claims arising under *Part A* of the Medicare Act. Pet. App. 6a-11a. In 1986, Congress amended those judicial review provisions—which had applied only to Part A—to include Part B claims. Pet. App. 8a-9a, 12a. In light of the 1986 amendment, the court of appeals found it "inescapable that the same rule[s] must [now] govern parts A and B." Pet. App. 12a. Accordingly, the court held that a district court may not assert jurisdiction over Part B claims where, as here, the claimant has failed to present a claim to the agency for payment under the policy or regulation at issue. Pet. App. 10a-13a.

a. The court of appeals distinguished this Court's decision in *Bowen* v. *Michigan Academy of Family Physicians*, 476 U.S. 667 (1986), which allowed judicial review of Part B methodology challenges in a suit based on the general judicial review provisions of the APA and 28 U.S.C. 1331. The court of appeals explained that *Michigan Academy*, which was decided before the 1986 amendment to the judicial review provisions, rested on the presumption that Congress did not intend to preclude *all* judicial review of serious statutory and constitutional questions arising under Part B. Pet. App. 11a-12a. The court of appeals concluded that *Michigan Academy* no longer governs Part B claims, because Congress has now provided a route for judicial review under 42 U.S.C. 405(g) after presentment and exhaustion

of the administrative process. Pet. App. 12a-13a. Under the 1986 amendment, "[P]art B claims will not go unreviewed; review simply awaits *initial* administrative determination in a concrete setting." Pet. App. 13a

b. The court of appeals also held that HHS, as a defendant injured by a wrongfully issued preliminary injunction, is presumptively entitled to obtain recovery from the injunction bond. Pet. App. 15a-17a. The court found that none of the equitable arguments raised by petitioners were sufficient to overcome that presumption. Pet. App. at 17a-18a. The court further ruled that HHS has the right to seek restitution in excess of the amount of the bond through the usual Medicare procedures for seeking recoupment of overpayments. *Id.* at 20a-22a. The court added that when HHS recoupment procedures "have run their full course, HIC may, if not content with the outcome, seek judicial relief in an appropriate forum." Pet. App. at 22a.[1]

ARGUMENT

The decision of the court of appeals is correct and is consistent with the decisions of this Court and the only other court of appeals to have decided the issue. Accordingly, further review is not warranted.

1. The court of appeals correctly held that petitioners were required to present a claim for Medicare benefits to the Secretary as a prerequisite to seeking judicial review.

a. The Medicare Act's judicial review provisions, 42 U.S.C. 1395ff(b), 1395ii, incorporate by reference the judicial review provisions of Title II of the Social Security

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[1] Petitioners do not seek review of these rulings by the court of appeals regarding HHS's rights to recovery.

Act, 42 U.S.C. 405(g), 405(h). In *Heckler* v. *Ringer*, 466 U.S. 602 (1984), the Court held that a claimant asserting claims arising under Part A of the Medicare Act must satisfy the same exhaustion requirement applicable under Section 405(g). The Court explained that this exhaustion requirement has two components: (1) a "nonwaivable" requirement that a claim for benefits must be presented to the Secretary; and (2) a "waivable" requirement that the claimant must have fully pursued the administrative review process. 466 U.S. at 617. See also *Mathews* v. *Eldridge*, 424 U.S. 319, 328 (1976); *Weinberger* v. *Salfi*, 422 U.S. 749, 763-765 (1975).

Mr. Ringer challenged the Secretary's policy concerning Part A Medicare insurance coverage of a surgical procedure known as a bilateral carotid body resection (BCBR). This Court held that because he had not filed a claim for reimbursement, he was barred from seeking judicial review under either the Medicare Act or the general grant of federal jurisdiction in 28 U.S.C. 1331. 466 U.S. at 621-622. The Court explained that because "Ringer has not given the Secretary an opportunity to rule on a concrete claim for reimbursement, he has not satisfied the nonwaivable exhaustion requirement of § 405(g)." *Id.* at 622.

b. Petitioners incorrectly assert (Pet. 15) that they need not present a claim for payment to the Secretary before seeking judicial review because *Ringer* only dealt with "amount determinations." Petitioners contend (Pet. 13-15) that parties challenging the Secretary's polices or methodologies may proceed directly to court without even filing a claim with the Secretary. Petitioners' contention is inconsistent with *Ringer*, which involved "methodology" challenges similar to those at issue in this case. Mr. Ringer sought to "invalidate the Secre-

tary's rule" regarding coverage of BCBR surgery, contending that the Secretary's instructions regarding reimbursement violated the Due Process Clause, the Administrative Procedure Act (APA), and the Medicare Act. 466 U.S. at 610, 623 n.13. The Court explained that Ringer was challenging the policy so that he could establish the right to payment on a claim at a later date. 466 U.S. at 621-626. This Court concluded that it made no difference whether the suit raised procedural objections or substantive challenges to the Secretary's regulations; Ringer could not seek judicial review without presenting a claim for payment. *Ibid.*[2]

c. This case involves claims under Part B of the Medicare Act. Prior to 1986, the judicial review provisions discussed in *Ringer* applied to Part A claims, but not to Part B claims. Indeed, the Medicare Act did not expressly furnish Part B claimants with *any* avenue for seeking judicial review, see 42 U.S.C. 1395ff(a)-(b) (1982 & Supp. II 1984). For that reason, this Court had held in *United States* v. *Erika, Inc.*, 456 U.S. 201, 210 (1982), that in light of the carefully drawn provisions of 42 U.S.C. 1395ff permitting judicial review of benefit amount determinations under Part A but not Part B, review of such determinations under Part B was implicitly precluded. Thereafter, in *Bowen* v. *Michigan Academy of Family Physicians*, 476 U.S. 667 (1986), this Court declined to read the Medicare Act as precluding all judicial review for Part B claimants. 476 U.S. at 678-681. Accordingly,

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[2] Petitioners argue (Pet. 14-15) that, because 42 U.S.C. 1395ff(b)(1)(C) applies to benefit "amount" determinations, it is only judicial review of such determinations that is impliedly precluded by 42 U.S.C. 1395ff. But petitioners overlook 42 U.S.C. 405(h), which expressly bars this suit, quite apart from any implied preclusion in 42 U.S.C. 1395ff.

the Court held that a party challenging the Secretary's methods and procedures relating to Part B claims could seek judicial review pursuant to the general judicial review provisions of the APA, with jurisdiction resting on 28 U.S.C. 1331.

Underpinning the Court's holding in *Michigan Academy* was "the strong presumption that Congress intends judicial review of administrative action." 476 U.S. at 670. Absent a clear Congressional statement to the contrary, the Court refused to read the Act to preclude all judicial review of challenges to directives and other actions taken by the Secretary, as distinguished from amount determinations by carriers. *Id.* at 680. As this Court recently explained in *McNary* v. *Haitian Refugee Center, Inc.*, 111 S. Ct. 888 (1991):

> Inherent in our analysis [in *Michigan Academy*] was the concern that absent such a construction of the judicial review provisions of the Medicare statute, there would be "no [judicial] review at all of substantial statutory and constitutional challenges to the Secretary's administration of Part B of the Medicare program."

111 S. Ct. at 899 (quoting *Michigan Academy*, 476 U.S. at 680).

d. Four months after this Court decided *Michigan Academy*, Congress amended 42 U.S.C. 1395ff(b)(1)(C) to authorize administrative *and judicial* review of Part B claims under the *identical* statutory scheme applicable to Part A claims. See Omnibus Budget Reconciliation Act of 1986, Pub. L. No. 99-509, § 9341, 100 Stat. 2037. Section 1395ff(b)(1)(C), as amended, now permits a claimant to obtain review of:

> the amount of benefits under part A *or part B* * * * [in] a hearing * * * by the Secretary * * * and to *judicial review* of the Secretary's final decision after such hearing as is provided in [42 U.S.C. 405(g)].

42 U.S.C. 1395ff(b)(1) (emphasis added). Thus, Part B claims are now subject to the same statutory review provisions as Part A claims. See Pet. App. 12a; *Abbey* v. *Sullivan*, No. 92-6055 (2d Cir. Sept. 28, 1992), slip op. 7081 ("Part B claims are now reviewed in the same manner as Part A claims."). As shown by this Court's decisions in *Ringer*, *supra*, *Bowen* v. *Yuckert*, 482 U.S. 137 (1987), and *Weinberger* v. *Salfi*, 422 U.S. at 756-767, challenges to regulations and even to the Act itself may and must be presented through this special statutory review procedure.

Because the statutory differences between Parts A and B that gave rise to the *Ringer/Michigan Academy* dichotomy have been eliminated, and because the fundamental premise of *Michigan Academy*'s analysis (the absence of any judicial review of Part B claims) is no longer applicable, the avenue for judicial review recognized in *Michigan Academy* is no longer available. See Pet. App. 12a-13a; *Abbey* v. *Sullivan*, slip op. 7080-7081; *Roen* v. *Sullivan*, 764 F. Supp. 555, 561 (D. Minn. 1991); see also *Westchester Management Corp.* v. *HHS*, 948 F.2d 279, 282 (6th Cir. 1991) ("the *Michigan Academy* exception applies only when there is no other avenue of judicial review"), cert. denied, 112 S. Ct. 1936 (1992). As the court of appeals here explained, under the 1986 amendment, "part B claims will not go unreviewed; review simply awaits *initial* administrative determination in a concrete setting." Pet. App. 13a.

e. Given that the same statutory review provisions now govern claims under Parts A and B, the court of ap-

peals correctly reached the "inescapable" conclusion that the same principles of judicial review "must [now] govern parts A and B." Pet. App. 12a. Accordingly, the court of appeals was plainly correct in holding that by bringing the Part B claims into the established Part A review framework, Congress intended to subject Part B claims to the same rules applicable to Part A claims under that existing framework. See H.R. Rep. No. 727, 99th Cong., 2d Sess. 95 (1986) (amendments establish "an appeals procedure under Part B that is modeled after that available under Part A"). See also *Abbey* v. *Sullivan*, slip op. 7078-7081 (holding that Part B claims are now governed by *Ringer*); *Roen* v. *Sullivan*, 764 F. Supp. 555, 561 (D. Minn. 1991) ("*Ringer*, which concerned Part A * * *, is now applicable to Part B claims as well."). Now, under both Part A and Part B, a party is at a minimum required to present a claim for benefits before seeking judicial review. As the APA itself makes clear, see 5 U.S.C. 703, a party may not circumvent this special statutory review procedure by resorting to the general judicial review provisions of the APA and the general jurisdictional grant in 28 U.S.C. 1331.[3]

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[3] We note that the jurisdictional issue addressed by the court of appeals has been the focus of recent legislative action. On October 22, 1992, Congress passed legislation that would have permitted direct judicial review of Part B challenges to regulations or Medicare instructions where no material issue of fact is in dispute. See H.R. 11, 102d Cong, 2d Sess. § 10210 (1992); see also 138 Cong. Rec. H12,379 (daily ed. Oct. 5, 1992) (setting out § 10210); 138 Cong. Rec. S18,262 (daily ed. Oct. 22, 1992). On November 5, 1992, that bill failed to become law under the "Pocket Veto" Clause, U.S. Const. Art. I, § 7, Cl. 2. 28 Weekly Comp. Pres. Doc. No. 45, at 2283 (1992).

2. a. The conflict in the courts of appeals alleged by petitioners is fictitious. As the court of appeals explained, this is the *first* case in which a court of appeals addressed the effect of the 1986 amendment on judicial review of Part B "methodology" claims. Pet. App. 15a. Since the court of appeals issued its decision in this case, one other court of appeals has addressed that issue. In *Abbey* v. *Sullivan*, *supra*, the Second Circuit fully agreed with the result and the reasoning in this case:

> [W]e agree with the only other Circuit to address this issue that "the special treatment of part B, based on the pre-October 1986 statutory differences, cannot survive the elimination of those differences." * * * Part B claims are now reviewed in the same manner as Part A claims so that the Social Security Act provides the exclusive authority for exercising jurisdiction over Part B disputes. See *Ringer*, 466 U.S. at 605.

Abbey, slip op. 7081 (quoting *National Kidney Patients Ass'n* v. *Sullivan*, 958 F.2d 1127, 1132 (D.C. Cir. 1992)).[4]

b. Petitioners also contend (Pet. 15) that the courts of appeals are in conflict over whether a *Part A* claimant raising a methodology challenge may seek judicial re-

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[4] Although petitioners contend (Pet. 15) that the decision in this case conflicts with other courts of appeals' decisions, none of the decisions cited by petitioners even discusses the 1986 amendments. Indeed, the cases cited by petitioners all involved pre-1987 Medicare claims. The 1986 amendment applies only to claims relating to services and items provided on or after *January 1, 1987*. See Omnibus Budget Reconciliation Act of 1986, Pub. L. No. 99-509, § 9341(b), 100 Stat. 2038. Decisions that did not concern (and therefore did not address) the 1986 amendment cannot establish a conflict concerning the jurisdictional rules applicable to Part B claims arising after the 1986 amendment.

view without filing a claim. As we explain above (pp. 8-9, *supra*), however, that issue was resolved in *Ringer*, which required presentment as a prerequisite for seeking judicial review of a methodology challenge. See also Pet. App. 10a, 12a-13a; *Westchester Management Corp.*, 948 F.2d at 282. In any event, the two decisions relied upon by petitioners do not conflict with the decision in this case.

In *McCuin* v. *Secretary of HHS*, 817 F.2d 161 (1st Cir. 1987), the type of claim at issue—a Part A claim involving less than $1,000—was not subject to any judicial review under 42 U.S.C. 1395ff. Thus *McCuin*, like *Michigan Academy*, raised the question whether Congress intended to preclude *all* judicial review of certain claims. As the Court held in *Michigan Academy*, there is a strong presumption in favor of judicial review of administrative action. Although we believe, contrary to the First Circuit in *McCuin*, that the amount-in-controversy requirement in 42 U.S.C. 1395ff(b)(2) is sufficient to overcome that presumption for claims involving less than the required amount, this case does not present that issue, because the amount-in-controversy requirement for invocation of the special statutory review procedure is met. As a result, in both *Ringer* and this case—in contrast to *McCuin*—there is no question that the plaintiffs could have sought judicial review under 42 U.S.C. 1395ff after presentment of a claim and exhaustion of the administrative process. See *Westchester Management Corp.*, 948 F.2d at 281-282 (the *Michigan Academy* methodology exception to *Ringer* "applies only when there is no other avenue of judicial review").

In *Bodimetric Health Services, Inc.* v. *Aetna Life & Casualty*, 903 F.2d 480 (7th Cir.), cert. denied, 111 S. Ct. 579 (1990), the court of appeals held that, because the

plaintiff could have sought review through the Medicare Act's administrative and judicial review process, that process was the exclusive means of obtaining judicial review. See *Bodimetric*, 903 F.2d at 486-487. That reasoning is entirely consistent with *Ringer* and the D.C. Circuit's decision in the present case.[5]

CONCLUSION

The petition for a writ of certiorari should be denied.

Respectfully submitted.

KENNETH W. STARR
Solicitor General

STUART M. GERSON
Assistant Attorney General

ANTHONY J. STEINMEYER
ROBERT M. LOEB
Attorneys

DECEMBER 1992

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[5] In dicta, the Seventh Circuit appeared to construe *Michigan Academy* as extending to any claim that cannot be remedied through the administrative process. See 903 F.2d at 486-487. It is far from clear that the Seventh Circuit would adhere to that approach in a case governed by the 1986 amendment. In any event, it was entirely possible for petitioners to obtain the result they sought—reversal of the carrier's decision to lower the reimbursement rate—through the administrative process. Consequently, even if the court of appeals had applied the Seventh Circuit's dicta, it would have required petitioners to present a claim and exhaust their administrative remedies.